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BTATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
Medical Board of California
BOARD OF PODIATRIC MEDICINE
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6. Legislative Committee

Ms. Dixon, *chair*
Dr. Longobardi, *vice*

a. Overview ..... **M**

Legislative highlights for 2010 included:

- ❖ SB 953 (Mimi Walters), sponsored by BPM, passed both the Senate and Assembly without a single "No" vote on either floor or in any committee.

  The bill eliminates B&P Code subsection 2397(d), thus enabling DPMs to provide any Good Samaritan emergency care with the same protection from liability as MDs and other providers, without regard to scope.

- ❖ SB 1111, the Administration's proposed *Consumer Health Care Enforcement Act*. BPM voted unanimously to back the bill and was the only body listed in support along with the Department of Consumer Affairs (DCA) in the Senate Business & Professions Committee bill analysis that went to the Senators. The bill failed in Committee April 22.

b. **Sunset review** ..... **N**

Exhibited here is Article 22 (Podiatric Medicine) of the State Medical Practice Act, Business & Professions Code. Section 2460 shows the current sunset date of January 1, 2013.

Senate B&P Committee Consultant Rosielyn Pulmano commented to the Board at its meeting July 26 that:

- ❖ Committee Consultant G.V.Ayers will send BPM the sunset review questionnaire in January or February of 2011
- ❖ The Senate and Assembly B&P Committees will hold joint hearings in October or November 2011, following submission of reports by BPM and other boards
- ❖ The Committees will sponsor sunset extension legislation in 2012
- ❖ Our report and the legislation may address public policy advances

The Governor has until September 30 to sign or veto all bills, including AB 2130 that repeals provisions making a board a bureau under DCA in the event it is sunsetted. Senate Committee staff say "This will require the Legislature to take an affirmative action to decide on the appropriate changes and continuation of the board prior to its sunset date."

The new sunset report requirements are expected to be less voluminous than in 1997 and 2001. The review and committee bill may be an opportunity, as before, to advance legislative proposals. Our Legislative Committee will review clean-up and modernization provisions in early 2011. Preparing this report and the Legislative hearings will be a major BPM activity next year, as will be monitoring the extension legislation in 2012.

"Boards are established to protect the people of California."
Section 101.6, B&P Code

establishing an Emergency Health Care Enforcement Reserve Fund which was inadvertently not removed from the bill in previous amendments.

NOTE : Double-referral to Judiciary Committee (second.)

SUPPORT AND OPPOSITION:

Support:

Department of Consumer Affairs (Sponsor)
California Board of Podiatric Medicine.

Oppose Unless Amended:

American Psychiatric Nurses Association, California Chapter
California Association of Marriage and Family Therapists
California Dental Association
California Psychiatric Association
California Psychological Association
California Society for Addiction Medicine
California Society for Clinical Social Work
California Nurses Association
National Association of Social Workers (CA Chapter)
Service Employees International Union

Opposition:

None on File as of April 13, 2010

Consultant:Rosielyn Pulmano

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BUSINESS AND PROFESSIONS CODE
SECTION 2460-2499.8

2460. (a) There is created within the jurisdiction of the Medical Board of California the California Board of Podiatric Medicine.

(b) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date. The repeal of this section renders the California Board of Podiatric Medicine subject to the review required by Division 1.2 (commencing with Section 473).

2460.1. Protection of the public shall be the highest priority for the California Board of Podiatric Medicine in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

2461. As used in this article:

(a) "Division" means the Division of Licensing of the Medical Board of California.

(b) "Board" means the California Board of Podiatric Medicine.

(c) "Podiatric licensing authority" refers to any officer, board, commission, committee, or department of another state that may issue a license to practice podiatric medicine.

2462. The board shall consist of seven members, three of whom shall be public members. Not more than one member of the board shall be a full-time faculty member of a college or school of podiatric medicine.

The Governor shall appoint the four members qualified as provided in Section 2463 and one public member. The Senate Rules Committee and the Speaker of the Assembly shall each appoint a public member.

2463. Each member of the board, except the public members, shall be appointed from persons having all of the following qualifications:

(a) Be a citizen of this state for at least five years next preceding his or her appointment.

(b) Be a graduate of a recognized school or college of podiatric medicine.

(c) Have a valid certificate to practice podiatric medicine in this state.

(d) Have engaged in the practice of podiatric medicine in this state for at least five years next preceding his or her appointment.

2464. The public members shall be appointed from persons having all of the following qualifications:

(a) Be a citizen of this state for at least five years next preceding his or her appointment.

(b) Shall not be an officer or faculty member of any college, school, or other institution engaged in podiatric medical instruction.

(c) Shall not be a licentiate of the board or of any board under this division or of any board created by an initiative act under this division.

2465. No person who directly or indirectly owns any interest in any college, school, or other institution engaged in podiatric medical instruction shall be appointed to the board or shall any incumbent member of the board have or acquire any interest, direct or indirect, in any such college, school, or institution.

2466. All members of the board shall be appointed for terms of four years. Vacancies shall immediately be filled by the appointing power for the unexpired portion of the terms in which they occur. No person shall serve as a member of the board for more than two consecutive terms.

2467. (a) The board may convene from time to time as it deems necessary.

(b) Four members of the board constitute a quorum for the transaction of business at any meeting.

(c) It shall require the affirmative vote of a majority of those members present at a meeting, those members constituting at least a quorum, to pass any motion, resolution, or measure.

(d) The board shall annually elect one of its members to act as president and a member to act as vice president who shall hold their respective positions at the pleasure of the board. The president may call meetings of the board and any duly appointed committee at a specified time and place.

2468. Notice of each meeting of the board shall be given in accordance with the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

2469. Each member of the board shall receive per diem and expenses as provided in Section 2016.

2470. The board may adopt, amend, or repeal, in accordance with the provisions of the Administrative Procedure Act, regulations necessary to enable the board to carry into effect the provisions of law relating to the practice of podiatric medicine.

2471. Except as provided by Section 159.5, the board may employ,

within the limits of the funds received by the board, all personnel necessary to carry out this chapter.

2472. (a) The certificate to practice podiatric medicine authorizes the holder to practice podiatric medicine.

(b) As used in this chapter, "podiatric medicine" means the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot.

(c) A doctor of podiatric medicine may not administer an anesthetic other than local. If an anesthetic other than local is required for any procedure, the anesthetic shall be administered by another licensed health care practitioner who is authorized to administer the required anesthetic within the scope of his or her practice.

(d) (1) A doctor of podiatric medicine who is ankle certified by the board on and after January 1, 1984, may do the following:

(A) Perform surgical treatment of the ankle and tendons at the level of the ankle pursuant to subdivision (e).

(B) Perform services under the direct supervision of a physician and surgeon, as an assistant at surgery, in surgical procedures that are otherwise beyond the scope of practice of a doctor of podiatric medicine.

(C) Perform a partial amputation of the foot no further proximal than the Chopart's joint.

(2) Nothing in this subdivision shall be construed to permit a doctor of podiatric medicine to function as a primary surgeon for any procedure beyond his or her scope of practice.

(e) A doctor of podiatric medicine may perform surgical treatment of the ankle and tendons at the level of the ankle only in the following locations:

(1) A licensed general acute care hospital, as defined in Section 1250 of the Health and Safety Code.

(2) A licensed surgical clinic, as defined in Section 1204 of the Health and Safety Code, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1) and meets all the protocols of the surgical clinic.

(3) An ambulatory surgical center that is certified to participate in the Medicare Program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1) and meets all the protocols of the surgical center.

(4) A freestanding physical plant housing outpatient services of a licensed general acute care hospital, as defined in Section 1250 of the Health and Safety Code, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1). For purposes of this section, a "freestanding physical plant" means any building that is not physically attached to a building where inpatient services are provided.

(5) An outpatient setting accredited pursuant to subdivision (g) of Section 1248.1 of the Health and Safety Code.

(f) A doctor of podiatric medicine shall not perform an admitting history and physical examination of a patient in an acute care hospital where doing so would violate the regulations governing the Medicare program.

(g) A doctor of podiatric medicine licensed under this chapter is

a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care practitioner subject to the provisions of Section 2290.5 pursuant to subdivision (b) of that section.

2474. Any person who uses in any sign or in any advertisement or otherwise, the word or words "doctor of podiatric medicine," "doctor of podiatry," "podiatric doctor," "D.P.M.," "podiatrist," "foot specialist," or any other term or terms or any letters indicating or implying that he or she is a doctor of podiatric medicine, or that he or she practices podiatric medicine, or holds himself out as practicing podiatric medicine or foot correction as defined in Section 2472, without having at the time of so doing a valid, unrevoked, and unsuspended certificate as provided for in this chapter, is guilty of a misdemeanor.

2475. Unless otherwise provided by law, no postgraduate trainee, intern, resident postdoctoral fellow, or instructor may engage in the practice of podiatric medicine, or receive compensation therefor, or offer to engage in the practice of podiatric medicine unless he or she holds a valid, unrevoked, and unsuspended certificate to practice podiatric medicine issued by the division. However, a graduate of an approved college or school of podiatric medicine upon whom the degree doctor of podiatric medicine has been conferred, who is issued a resident's license, which may be renewed annually for up to four years for this purpose by the division upon recommendation of the board, and who is enrolled in a postgraduate training program approved by the board, may engage in the practice of podiatric medicine whenever and wherever required as a part of that program and may receive compensation for that practice under the following conditions:

(a) A graduate with a resident's license in an approved internship, residency, or fellowship program may participate in training rotations outside the scope of podiatric medicine, under the supervision of a physician and surgeon who holds a medical doctor or doctor of osteopathy degree wherever and whenever required as a part of the training program, and may receive compensation for that practice. If the graduate fails to receive a license to practice podiatric medicine under this chapter within three years from the commencement of the postgraduate training, all privileges and exemptions under this section shall automatically cease.

(b) Hospitals functioning as a part of the teaching program of an approved college or school of podiatric medicine in this state may exchange instructors or resident or assistant resident doctors of podiatric medicine with another approved college or school of podiatric medicine not located in this state, or those hospitals may appoint a graduate of an approved school as such a resident for purposes of postgraduate training. Those instructors and residents may practice and be compensated as provided in this section, but that practice and compensation shall be for a period not to exceed two years.

2475.1. Before a resident's license may be issued, each applicant shall show by evidence satisfactory to the board, submitted directly to the board by the national score reporting institution, that he or she has, within the past 10 years, passed Parts I and II of the examination administered by the National Board of Podiatric Medical Examiners of the United States or has passed a written examination

that is recognized by the board to be the equivalent in content to the examination administered by the National Board of Podiatric Medical Examiners of the United States.

2475.2. As used in this article, "podiatric residency" means a program of supervised postgraduate clinical training, one year or more in duration, approved by the board.

2475.3. (a) The board shall approve podiatric residency programs, as defined in Section 2475.2, in the field of podiatric medicine, for persons who are applicants for or have been issued a certificate to practice podiatric medicine pursuant to this article.

(b) The board may only approve a podiatric residency that it determines meets all of the following requirements:

(1) Reasonably conforms with the Accreditation Council for Graduate Medical Education's Institutional Requirements of the Essentials of Accredited Residencies in Graduate Medical Education: Institutional and Program Requirements.

(2) Is approved by the Council on Podiatric Medical Education.

(3) Complies with the requirements of this state.

2476. Nothing in this chapter shall be construed to prevent a regularly matriculated student undertaking a course of professional instruction in an approved college or school of podiatric medicine from participating in training beyond the scope of podiatric medicine under the supervision of a physician and surgeon who holds a medical doctor or doctor of osteopathy degree whenever and wherever prescribed as part of his or her course of study.

2477. Nothing in this chapter prohibits the manufacture, the recommendation, or the sale of either corrective shoes or appliances for the human feet.

2479. The division shall issue, upon the recommendation of the board, a certificate to practice podiatric medicine to each applicant who meets the requirements of this chapter. Every applicant for a certificate to practice podiatric medicine shall comply with the provisions of Article 4 (commencing with Section 2080) which are not specifically applicable to applicants for a physician's and surgeon's certificate, in addition to the provisions of this article.

2480. The board shall have full authority to investigate and to evaluate each applicant applying for a certificate to practice podiatric medicine and to make a determination of the admission of the applicant to the examination and the issuance of a certificate in accordance with the provisions and requirements of this chapter.

2481. Each applicant who commenced professional instruction in

podiatric medicine after September 1, 1959, shall show by an official transcript or other official evidence submitted directly to the board by the academic institution that he or she has completed two years of preprofessional postsecondary education, or its equivalent, including the subjects of chemistry, biology or other biological science, and physics or mathematics, before completing the resident course of professional instruction.

2483. (a) Each applicant for a certificate to practice podiatric medicine shall show by an official transcript or other official evidence satisfactory to the board that is submitted directly to the board by the academic institution that he or she has successfully completed a medical curriculum extending over a period of at least four academic years, or 32 months of actual instruction, in a college or school of podiatric medicine approved by the board. The total number of hours of all courses shall consist of a minimum of 4,000 hours.

The board, by regulation, shall adopt standards for determining equivalent training authorized by this section.

(b) The curriculum for all applicants shall provide for adequate instruction related to podiatric medicine in the following:

Alcoholism and other chemical substance detection
Local anesthesia
Anatomy, including embryology, histology, and neuroanatomy
Behavioral science
Biochemistry
Biomechanics-foot and ankle
Child abuse detection
Dermatology
Geriatric medicine
Human sexuality
Infectious diseases
Medical ethics
Neurology
Orthopedic surgery
Pathology, microbiology, and immunology
Pediatrics
Pharmacology, including materia medica and toxicology
Physical and laboratory diagnosis
Physical medicine
Physiology
Podiatric medicine
Podiatric surgery
Preventive medicine, including nutrition
Psychiatric problem detection
Radiology and radiation safety
Spousal or partner abuse detection
Therapeutics
Women's health

2484. In addition to any other requirements of this chapter, before a certificate to practice podiatric medicine may be issued, each applicant shall show by evidence satisfactory to the board, submitted directly to the board by the sponsoring institution, that he or she has satisfactorily completed at least two years of postgraduate podiatric medical and podiatric surgical training in a general acute care hospital approved by the Council of Podiatric Medical Education.

2486. The Medical Board of California shall issue, upon the recommendation of the board, a certificate to practice podiatric medicine if the applicant has submitted directly to the board from the credentialing organizations verification that he or she meets all of the following requirements:

(a) The applicant has graduated from an approved school or college of podiatric medicine and meets the requirements of Section 2483.

(b) The applicant, within the past 10 years, has passed parts I, II, and III of the examination administered by the National Board of Podiatric Medical Examiners of the United States or has passed a written examination that is recognized by the board to be the equivalent in content to the examination administered by the National Board of Podiatric Medical Examiners of the United States.

(c) The applicant has satisfactorily completed the postgraduate training required by Section 2484.

(d) The applicant has passed within the past 10 years any oral and practical examination that may be required of all applicants by the board to ascertain clinical competence.

(e) The applicant has committed no acts or crimes constituting grounds for denial of a certificate under Division 1.5 (commencing with Section 475).

(f) The board determines that no disciplinary action has been taken against the applicant by any podiatric licensing authority and that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of podiatric medicine that the board determines constitutes evidence of a pattern of negligence or incompetence.

(g) A disciplinary databank report regarding the applicant is received by the board from the Federation of Podiatric Medical Boards.

2488. Notwithstanding any other provision of law, the Medical Board of California shall issue, upon the recommendation of the board, a certificate to practice podiatric medicine by credentialing if the applicant has submitted directly to the board from the credentialing organizations verification that he or she is licensed as a doctor of podiatric medicine in any other state and meets all of the following requirements:

(a) The applicant has graduated from an approved school or college of podiatric medicine.

(b) The applicant, within the past 10 years, has passed either part III of the examination administered by the National Board of Podiatric Medical Examiners of the United States or a written examination that is recognized by the board to be the equivalent in content to the examination administered by the National Board of Podiatric Medical Examiners of the United States.

(c) The applicant has satisfactorily completed a postgraduate training program approved by the Council on Podiatric Medical Education.

(d) The applicant, within the past 10 years, has passed any oral and practical examination that may be required of all applicants by the board to ascertain clinical competence.

(e) The applicant has committed no acts or crimes constituting grounds for denial of a certificate under Division 1.5 (commencing with Section 475).

(f) The board determines that no disciplinary action has been taken against the applicant by any podiatric licensing authority and that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of podiatric medicine that the board determines constitutes evidence of a pattern of negligence or incompetence.

(g) A disciplinary databank report regarding the applicant is received by the board from the Federation of Podiatric Medical Boards.

2492. (a) The board shall examine every applicant for a certificate to practice podiatric medicine to ensure a minimum of entry-level competence at the time and place designated by the board in its discretion, but at least twice a year.

(b) Unless the applicant meets the requirements of Section 2486, applicants shall be required to have taken and passed the examination administered by the National Board of Podiatric Medical Examiners.

(c) The board may appoint qualified persons to give the whole or any portion of any examination as provided in this article, who shall be designated as examination commissioners. The board may fix the compensation of those persons subject to the provisions of applicable state laws and regulations.

(d) The provisions of Article 9 (commencing with Section 2170) shall apply to examinations administered by the board except where those provisions are in conflict with or inconsistent with the provisions of this article. In respect to applicants under this article any references to the "Division of Licensing" or "division" shall be deemed to apply to the board.

2493. (a) An applicant for a certificate to practice podiatric medicine shall pass an examination in the subjects required by Section 2483 in order to ensure a minimum of entry-level competence.

(b) The board shall require a passing score on the National Board of Podiatric Medical Examiners Part III examination that is consistent with the postgraduate training requirement in Section 2484. The board, as of July 1, 2005, shall require a passing score one standard error of measurement higher than the national passing scale score until such time as the National Board of Podiatric Medical Examiners recommends a higher passing score consistent with Section 2484. In consultation with the Office of Professional Examination Services of the Department of Consumer Affairs, the board shall ensure that the part III examination adequately evaluates the full scope of practice established by Section 2472, including amputation and other foot and ankle surgical procedures, pursuant to Section 139.

2495. Notwithstanding any other provision of this chapter, the board may delegate to officials of the board the authority to approve the admission of applicants to the examination and to approve the issuance of certificates to practice podiatric medicine to applicants who have met the specific requirements therefor in routine cases where applicants clearly meet the requirements of this chapter.

2496. In order to ensure the continuing competence of persons licensed to practice podiatric medicine, the board shall adopt and administer regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) requiring continuing education of those licensees. The board shall require those licensees to demonstrate satisfaction of the continuing education requirements and one of the following requirements at each license renewal:

(a) Passage of an examination administered by the board within the past 10 years.

(b) Passage of an examination administered by an approved specialty certifying board within the past 10 years.

(c) Current diplomate, board-eligible, or board-qualified status granted by an approved specialty certifying board within the past 10 years.

(d) Recertification of current status by an approved specialty certifying board within the past 10 years.

(e) Successful completion of an approved residency or fellowship program within the past 10 years.

(f) Granting or renewal of current staff privileges within the past five years by a health care facility that is licensed, certified, accredited, conducted, maintained, operated, or otherwise approved by an agency of the federal or state government or an organization approved by the Medical Board of California.

(g) Successful completion within the past five years of an extended course of study approved by the board.

(h) Passage within the past 10 years of Part III of the examination administered by the National Board of Podiatric Medical Examiners.

2497. (a) The board may order the denial of an application for, or the suspension of, or the revocation of, or the imposition of probationary conditions upon, a certificate to practice podiatric medicine for any of the causes set forth in Article 12 (commencing with Section 2220) in accordance with Section 2222.

(b) The board may hear all matters, including but not limited to, any contested case or may assign any such matters to an administrative law judge. The proceedings shall be held in accordance with Section 2230. If a contested case is heard by the board itself, the administrative law judge who presided at the hearing shall be present during the board's consideration of the case and shall assist and advise the board.

2497.5. (a) The board may request the administrative law judge, under his or her proposed decision in resolution of a disciplinary proceeding before the board, to direct any licensee found guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case.

(b) The costs to be assessed shall be fixed by the administrative law judge and shall not in any event be increased by the board. When the board does not adopt a proposed decision and remands the case to an administrative law judge, the administrative law judge shall not increase the amount of any costs assessed in the proposed decision.

(c) When the payment directed in the board's order for payment of costs is not made by the licensee, the board may enforce the order for payment by bringing an action in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee directed to pay costs.

(d) In any judicial action for the recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(e) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship

and who enters into a formal agreement with the board to reimburse the board within that one year period for those unpaid costs.

(f) All costs recovered under this section shall be deposited in the Board of Podiatric Medicine Fund as a reimbursement in either the fiscal year in which the costs are actually recovered or the previous fiscal year, as the board may direct.

2498. (a) The board shall have the responsibility for reviewing the quality of podiatric medical practice carried out by persons licensed to practice podiatric medicine.

(b) Each member of the board, or any licensed doctor of podiatric medicine appointed by the board, shall additionally have the authority to inspect, or require reports from, a general or specialized hospital and the podiatric medical staff thereof, with respect to the podiatric medical care, services, or facilities provided therein, and may inspect podiatric medical patient records with respect to the care, services, or facilities. The authority to make inspections and to require reports as provided by this section shall not be delegated by a member of the board to any person other than a doctor of podiatric medicine and shall be subject to the restrictions against disclosure described in Section 2263.

2499. There is in the State Treasury the Board of Podiatric Medicine Fund. Notwithstanding Section 2445, the division shall report to the Controller at the beginning of each calendar month for the month preceding the amount and source of all revenue received by it on behalf of the board, pursuant to this chapter, and shall pay the entire amount thereof to the Treasurer for deposit into the fund. All revenue received by the board and the division from fees authorized to be charged relating to the practice of podiatric medicine shall be deposited in the fund as provided in this section, and shall be used to carry out the provisions of this chapter relating to the regulation of the practice of podiatric medicine.

2499.5. The following fees apply to certificates to practice podiatric medicine. The amount of fees prescribed for doctors of podiatric medicine shall be those set forth in this section unless a lower fee is established by the board in accordance with Section 2499.6. Fees collected pursuant to this section shall be fixed by the board in amounts not to exceed the actual costs of providing the service for which the fee is collected.

(a) Each applicant for a certificate to practice podiatric medicine shall pay an application fee of twenty dollars ($20) at the time the application is filed. If the applicant qualifies for a certificate, he or she shall pay a fee which shall be fixed by the board at an amount not to exceed one hundred dollars ($100) nor less than five dollars ($5) for the issuance of the certificate.

(b) The oral examination fee shall be seven hundred dollars ($700), or the actual cost, whichever is lower, and shall be paid by each applicant. If the applicant's credentials are insufficient or if the applicant does not desire to take the examination, and has so notified the board 30 days prior to the examination date, only the examination fee is returnable to the applicant. The board may charge an examination fee for any subsequent reexamination of the applicant.

(c) Each applicant who qualifies for a certificate, as a condition

precedent to its issuance, in addition to other fees required by this section, shall pay an initial license fee. The initial license fee shall be eight hundred dollars ($800). The initial license shall expire the second year after its issuance on the last day of the month of birth of the licensee. The board may reduce the initial license fee by up to 50 percent of the amount of the fee for any applicant who is enrolled in a postgraduate training program approved by the board or who has completed a postgraduate training program approved by the board within six months prior to the payment of the initial license fee.

(d) The biennial renewal fee shall be nine hundred dollars ($900). Any licensee enrolled in an approved residency program shall be required to pay only 50 percent of the biennial renewal fee at the time of his or her first renewal.

(e) The delinquency fee is one hundred fifty dollars ($150).

(f) The duplicate wall certificate fee is forty dollars ($40).

(g) The duplicate renewal receipt fee is forty dollars ($40).

(h) The endorsement fee is thirty dollars ($30).

(i) The letter of good standing fee or for loan deferment is thirty dollars ($30).

(j) There shall be a fee of sixty dollars ($60) for the issuance of a resident's license under Section 2475.

(k) The application fee for ankle certification under Section 2472 for persons licensed prior to January 1, 1984, shall be fifty dollars ($50). The examination and reexamination fee for this certification shall be seven hundred dollars ($700).

(l) The filing fee to appeal the failure of an oral examination shall be twenty-five dollars ($25).

(m) The fee for approval of a continuing education course or program shall be one hundred dollars ($100).

2499.6. The fees in this article shall be fixed by the board in accordance with Section 313.1.

2499.8. Any licensee who demonstrates to the satisfaction of the board that he or she is unable to practice podiatric medicine due to a disability may request a waiver of the license renewal fee. The granting of a waiver shall be at the discretion of the board and may be terminated at any time. Waivers shall be based on the inability of a licensee to practice podiatric medicine. A licensee whose renewal fee has been waived pursuant to this section shall not engage in the practice of podiatric medicine unless and until the licensee pays the current renewal fee and does either of the following:

(a) Establishes to the satisfaction of the board, on a form prescribed by the board and signed under penalty of perjury, that the licensee's disability either no longer exists or does not affect his or her ability to practice podiatric medicine safely.

(b) Signs an agreement on a form prescribed by the board, signed under penalty of perjury, in which the licensee agrees to limit his or her practice in the manner prescribed by the reviewing physician.

Exhibit

O

President's *Message*

Foot Soldiers in the Battle for Recognition

By KATHLEEN M. STONE, DPM

Despite evidence that care by a podiatrist has a significant impact on outcomes in patients with diabetes, we podiatric physicians still are not a fully recognized arm of our patients' diabetes care. Today's podiatrist is uniquely qualified to treat the foot and ankle based on education, training, and experience, but too many podiatric physicians still are waiting for that recognition. Armed with concrete evidence of our value to patients, to the economy, and to the medical profession, I believe we must redouble our efforts to gain the recognition we deserve in the medical community.

Fortunately, we have new and dramatic evidence to support our demands. Patients with diabetes who receive medical and surgical care from a podiatrist are significantly less likely to suffer hospitalization or amputation than patients who do not receive care from a podiatrist. This podiatry-affirming finding comes from an APMA-sponsored study from Thomson Reuters, an independent, internationally respected research firm with expertise in the health-care market.

The study examined claims records for more than 32,000 patients with diabetes ages 18–64 and more than 43,000 patients over 65. Thomson Reuters matched health and risk factors for those who had podiatry visits to those who did not. Care by a podiatric physician, defined as at least one pre-ulcer visit, was associated with significantly lower risk of hospitalization and amputation: 29 percent lower odds of amputation and 24 percent lower odds of hospitalization in the 18–64-year-old population, and 9 percent lower odds of hospitalization and 23 percent lower odds of major amputation in patients over 65. Vickie Driver, MS, DPM, associate professor of surgery at Boston University School of Medicine, presented these astounding results during the APMA Annual Scientific Meeting in July in Seattle. For more information on the study, see the interview with Dr. Driver and her coauthor, James Wrobel, DPM, in this issue.

Diabetes is an epidemic in the United States. According to the American Diabetes Association, nearly 24 million Americans have diabetes, and an additional 1.6 million new cases are diagnosed each year.[1] As the number of patients with diabetes grows, so too will the number of amputations and hospitalizations. These patients have a chronic illness, and they need preventive care from a podiatrist to keep them out of hospitals and off the operating table.

Please be involved, be active, and be part of the battle to defend our profession!

Hospitalizations and amputations ultimately will add to the skyrocketing costs of health care in America. An investment in care by podiatrists, however, could save close to $200 million, according to the Thomson Reuters data.

Our states have responded to our call to action. The Colorado Podiatric Medical Association (CPMA) recently achieved victory when the association convinced not only state regulators, but also the state medical society, to support an updated scope of podiatric practice. Read more in "Colorado Updates Scope of Practice: A Case Study in State Advocacy," also in this issue. In Virginia, a solid grassroots advocacy strategy helped retain Medicaid coverage for podiatric medicine for this year. The Virginia Podiatric Medical Association (VPMA) already has requested the results of the Thomson Reuters study in order to put them to use in ongoing advocacy efforts. (The results will be published in two peer-reviewed journals, including the *Journal of the American Podiatric Medical Association*, later this year and will be available for use in advocacy efforts at that time.)

We owe a great deal to state components like CPMA and VPMA for their tireless advocacy efforts. We need every APMA member to continue doing battle for our profession in order to take this message to a national level and achieve recognition under Title XIX.

That's why it is critically important that APMA members become actively involved in Today's Podiatrist, APMA's campaign to increase awareness about the benefits of podiatry among medical professionals, the general public, and students. I'm excited to tell you that the campaign makes its public debut this month with new tools, including a dedicated website, an online video, a "widget," and more. See the article on page 16 in this issue (and find out just what a widget is). Visit **www.todayspodiatrist.com** to learn more and find out how you can be involved.

Today's Podiatrist is an outstanding opportunity for every member to help elevate the perception of podiatric medicine, create and solidify relationships with medical allies, further Vision 2015, and unify the profession.

I know how frustrated many of you are. We have waged a long battle for recognition as physicians, surgeons, and specialists. We've struggled with politics, bureaucracy, and ignorance. But we must channel our anger and frustration into advocacy. Madeleine Albright has said she is both an idealistic realist and a realistic idealist. I feel the same: As an idealistic realist, I know it will be difficult to achieve our goals. But as a realistic idealist, I know that we can and *must* achieve them, despite the sacrifice they may require.

Please be involved, be active, and be part of the battle to defend our profession! With more determination and more soldiers, we can be victorious. ■

---

1 American Diabetes Association. "Diabetes Statistics." **http://www.diabetes.org/diabetes-basics/diabetes-statistics/** (accessed June 28, 2010).

oday's Podiatrist Campaign Goes Public: What You Need to Know

APMA first introduced Today's Podiatrist in March and now is actively promoting the campaign to the public.

APMA has spent six months familiarizing membership with the campaign and enlisting 19 state associations and many individual members to help spread the message. The second phase of the campaign launch includes several new developments that you as an APMA member should know about to help make Today's Podiatrist the most successful awareness campaign the profession has ever seen. Member tip sheets and informational materials will continue to be available at **www.apma.org/todayspodiatrist** to download and use in your practices.

Landing Site

A new website, **TodaysPodiatrist.com**, is now live on the Web and will be central to the campaign—providing detailed information for each of Today's Podiatrist's three target audiences: ***patients*** (the consumer public, with a slight lean toward women ages 35–55); ***students*** interested in a career in medicine; and ***medical professionals***. **TodaysPodiatrist.com** is a vibrant, engaging, and highly interactive site that is clearly segmented for

TODAY'S
PODIATRIST
PHYSICIAN • SURGEON • SPECIALIST

each of these three audiences. Upon first visiting the **Todays Podiatrist.com** homepage, you will notice several focal points—colorful feature images highlighting different topics in podiatric medicine, large buttons that make it easy to find a local podiatrist, and a one-click feature to sign up for one of the Today's Podiatrist newsletters.

TodaysPodiatrist.com

Because social media will play a significant role in the campaign, easy-to-locate buttons to connect with APMA's Facebook, Twitter, and YouTube pages are front and center. Updates on the Today's Podiatrist campaign will be distributed through these channels. An interesting and interactive "foot-health timeline" provides users with information on common foot ailments seen at six stages of life. The homepage also will feature a downloadable PDF titled "What are Your Feet Saying About You?" The PDF describes chief causes and treatments for foot ailments such as bunions, blisters, and heel pain.

Each of the interior pages features specific information targeted towards each audience. For patients, there is information describing why caring for the feet and visiting a podiatrist regularly are important to staying healthy throughout life. Students can learn how a career in podiatric medicine is both challenging and rewarding. Medical professionals can peruse compelling information about the importance of including a podiatrist in their medical treatment team and why referring to a podiatrist can help save limbs and lives. Additionally, each audience will have its own Today's Podiatrist newsletter, with regularly updated content delivered via e-mail.

"Meet Your Feet" Online Video

If you attended July's Annual Scientific Meeting in Seattle, you were among the first to view the new online video promoting Today's Podiatrist. Titled "Meet Your Feet," the fast-paced, high-energy video uses upbeat music and narration along with a video technique called stop-motion animation to highlight foot facts, while describing the role of today's podiatrist. **TodaysPodiatrist.com** prominently features this video, which can be placed on your practice's website to encourage others to meet their feet and make an appointment with a podiatrist. The video also is on APMA's YouTube page, and we encourage you to share it with friends, family, and patients.

Because social media will play a significant role in the campaign, easy-to-locate buttons to connect with APMA's Facebook, Twitter, and YouTube pages are front and center. Updates on the Today's Podiatrist campaign will be distributed through these channels.

continued on page 18

Today's Podiatrist continued from page 17

Today's Podiatrist Widget

The "Meet Your Feet" video also will be included in a shareable online tool called a widget. Much like the popular "apps" available to download on smartphones, the Today's Podiatrist widget is a unique application that provides several useful functions for anyone who wants to download it to his or her computer or website. Users can watch the "Meet Your Feet" video in the widget, use the foot health timeline tool featured on the **TodaysPodiatrist.com** homepage, locate a podiatrist in their area, and get tips that will help them best prepare for an appointment. The widget—even after it has been downloaded—will continue to update with fresh content and information, providing campaign news for a long time to come.

The new Today's Podiatrist poster series is available free of charge to members to help promote the campaign.

Media Promotion and Advertising

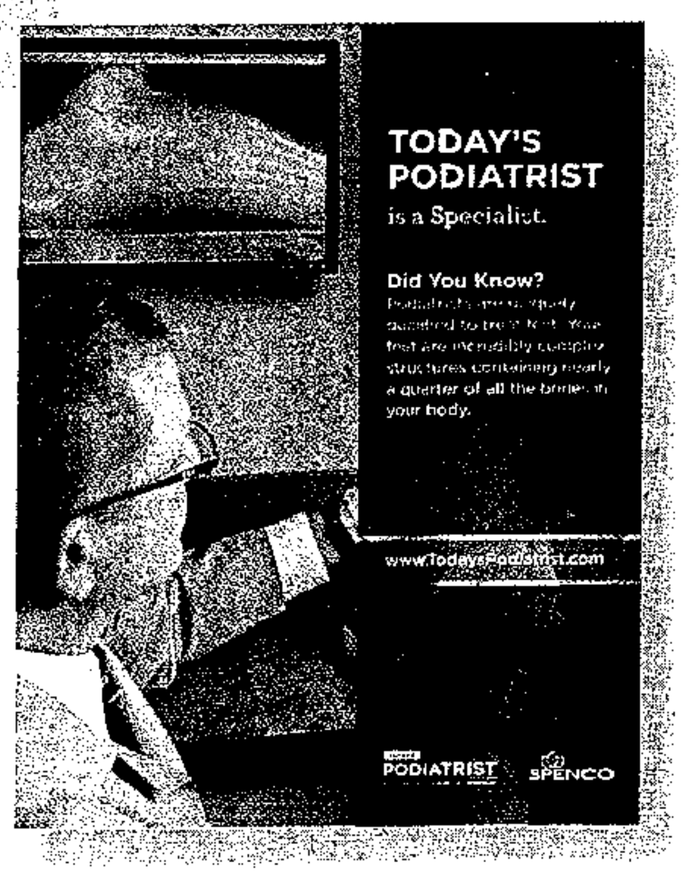
In addition to the Web-based tools above, APMA also will implement a targeted media plan to promote Today's Podiatrist on popular health websites that all of the campaign's target audiences visit—especially the demographic of women ages 35–55, who have been found to be the health-care decision makers for the family. Keep an eye out for Today's Podiatrist advertising—on the Internet and beyond!

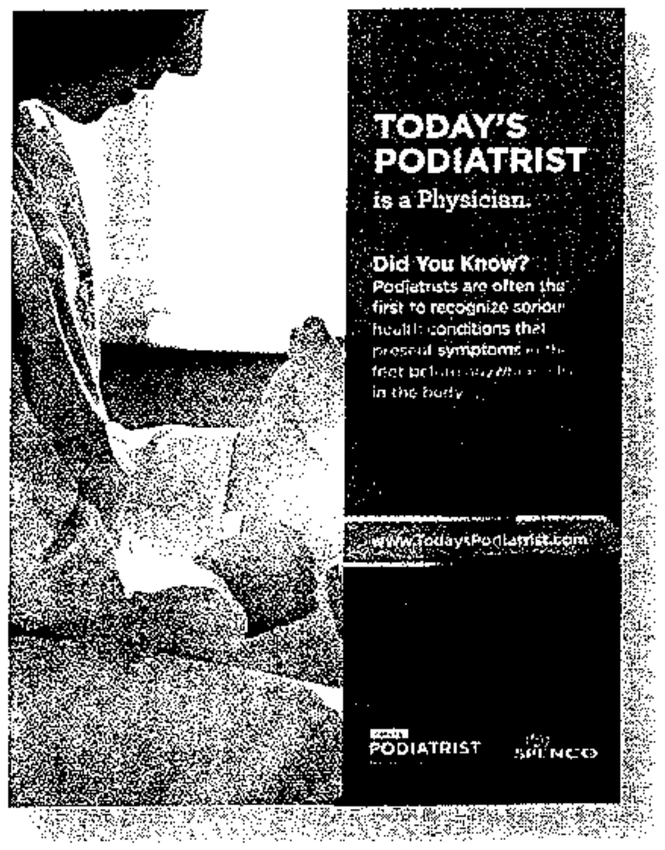
APMA also has created a series of brand new Today's Podiatrist posters for your practice. These are not only eye-catching, but also provide interesting facts about podiatry that will serve as conversation starters between doctors and patients. View the posters at **www.apma.org/todayspodiatrist** and e-mail orders to Angela Berard at **ahberard@apma.org**.

Member Involvement More Important than Ever!

Today's Podiatrist is a long-term campaign—and now, more than ever before, APMA members must keep enthusiasm for this campaign going. As APMA President Kathleen Stone, DPM, has noted, Today's Podiatrist will be as successful for podiatry as APMA members make it.

What can you do? Make sure to tell patients about **Todays Podiatrist.com** and the helpful information they can find there. Download the widget to your practice website. Use the new posters to talk to patients about the surgical training of today's podiatrist. View the "Meet Your Feet" video on YouTube. Order the latest Today's Podiatrist brochure from **www.apma.org**. Proudly proclaim that you are today's podiatrist!





The Public Relations staff is always ready to help you use the existing member tools, as well as the brand new **TodaysPodiatrist.com** website, video, widget, and more. Today's podiatrist is not only a physician, surgeon, and specialist … you are also the most important outlet to take this message to the public! ■

For more information, contact Mike Kulick at mskulick@apma.org *or Angela Berard at* ahberard@apma.org.

MEET YOUR FEET

We don't really think about our feet, we just expect them to perform. We expect that at times they'll be uncomfortable, and we put up with it when they hurt. But healthy feet are fundamental to the quality of our lives. They're truly amazing and wondrously engineered, and we need to look after them. Our feet are often the canary in the coal mine—they are indicators of our overall health. Signs of arthritis, diabetes, and nerve and circulatory disorders can all be detected in our feet. So we must ensure that they get the expert care they need and deserve at all stages in our lives. Podiatrists are highly trained physicians and surgeons focusing on the foot and ankle and should be an important part of our health care team.

According to podiatric physicians, walking is the best of all foot exercises.

Diabetes is the leading cause of non-traumatic lower-limb amputation.

An average day of walking brings a force equal to several hundred tons to your feet. Choose the right shoes.

FIND A PODIATRIST

Feet are incredibly complex and require expert care. Find a podiatrist near you today.

Mile Radius
5 10 25

FIND

E-NEWSLETTER SIGNUP

Sign up for the Today's Podiatrist newsletter.

enter email address here

SUBMIT

CONNECT WITH US

PREPARE FOR YOUR APPOINTMENT

Foot health is critical to overall health. Learn more about how to prepare for your appointment with a podiatrist.

DOWNLOAD PDF

ASK THE EXPERT

Feeling the pain in your feet? Ask Today's Podiatrist about it now on apma.org.

Ask a Question

Click here to read past questions and answers on APMA.org.

GLOSSARY OF TERMS

A B C D E F G H
I J K L M N O P
R S T U V W X All

CONSIDERING A CAREER IN MEDICINE?

Podiatrists are highly trained physicians and surgeons who treat one of the most fundamental parts of the body. Feet are complex anatomical structures, all-in-one stabilizers, shock absorbers, and propulsion engines that are instrumental to overall health and well-being. In practice, podiatrists can specialize in a variety of areas from sports medicine to pediatrics to surgery. They work in a variety of settings including private practices, clinics, hospitals, and educational environments. Many podiatrists own their own businesses. Podiatrists are the only doctors to receive specialized medical and surgical training and board certification solely in the care of the lower extremity.

With diabetes on the rise, more people exercising, and Americans growing older, the demand for podiatrists continues to increase.

Podiatrists are well-compensated and enjoy a healthy work-life balance.

For more information on podiatric medical education, visit www.apma.org/careers.

FIND A PODIATRIST

Feet are incredibly complex and require expert care. Find a podiatrist near you today.

Mile Radius
· 5 10
25

FIND

E-NEWSLETTER SIGNUP

Sign up for the Today's Podiatrist newsletter.

SUBMIT

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VIDEOS

Today's Podiatrist Does It All
A "music video" on careers in podiatric medicine.

Who is "Today's Podiatrist?"
Today's podiatrists speak out about their experiences.

PODCASTS

Starting a Career in Podiatric Medicine
An interview with Dr. Nancy Parsley and two podiatry students ...

COMING TO YOUR CAMPUS

DPM Mentors make career presentations on many college campuses. Select a state to find upcoming events near you.

Find Local Events State

Next Event

University of Delaware Careers in Podiatric Medicine
October 4, 2010
Dr. David Haley will present his views on careers in podiatric medicine to...

SHADOW A PODIATRIST

Meet your future. Shadow a podiatrist or invite one to discuss podiatry with your classmates.

Full Name:

Email:

MEET TODAY'S PODIATRIST

Dr. Patrick DeHeer: Doctor on a Mission

Podiatric medicine has allowed Dr. Patrick DeHeer to fulfill his dream of being a medical missionary. Read more about his story here.

Dr. Kittra Owens: Military Doctor

Athlete, doctor, and lieutenant: as an officer in the U.S. Navy, Kittra Owens, DPM "has it all." Read about Dr. Owens here.

Dr. Perry Julien: Sports Medicine Specialist

RESOURCES

GET THE TODAY'S PODIATRIST WIDGET

Our feet are the furthest things from our mind, but healthy feet are fundamental to the quality of our lives. Learn more about your feet and find a podiatrist near you.

Learn about common foot ailments, find a local podiatrist, prepare for an appointment and more with this handy widget! Share this widget with your friends and family by posting about it on Facebook or Twitter, or by embedding it on your own website.

To share on Facebook or Twitter, click below.

To embed the widget on your website, just copy the code below and paste it into the html of the page on your website where you want it to appear.

```
<iframe
src="http://www.todayspodiatrist.com
/services/widget" height="415"
width="300" frameborder="0"></iframe>
```

FIND A PODIATRIST

Feet are incredibly complex and require expert care. Find a podiatrist near you today.

Mile Radius
5 10
25

FIND

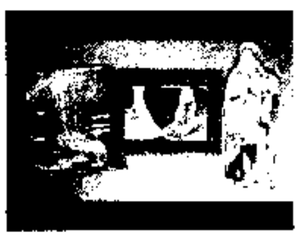
E-NEWSLETTER SIGNUP

Sign up for the Today's Podiatrist newsletter.

SUBMIT

CONNECT WITH US

VIDEOS



Meet Your Feet
September 3, 2010

Inherit the Facts: Conversations on Diabetes
December 7, 2009
First-hand account of how the disease has impacted...

Today's Podiatrist Does It All
A "music video" on careers in podiatric medicine.

Who is "Today's Podiatrist?"
Today's podiatrists speak out about their experiences.

Podiatric Medicine: A Career That Fits Your Future
April 7, 2009
This award-winning video is designed to educate...

PODCASTS

Starting a Career in Podiatric Medicine
An interview with Dr. Nancy Parsley and two podiatry students ...

Summertime Feet with REAL SIMPLE and APMA
Featuring APMA member podiatrist Dr. Marlene Reid and REAL SIMPLE magazine...

War Wounds Research
Featuring Lt. Col. Michael Neary, a podiatrist treating frontline injuries...

EVENTS

University of Delaware - Careers in Podiatric Medicine
October 4, 2010
Dr. David Haley will present his views on careers in podiatric medicine to...

Marist College hosts R. Daniel Davis, DPM
October 6, 2010
APMA Board Member, Dr. Dan Davis will once again speak to Pre-Med students...

APMA

Founded in 1912, the American Podiatric Medical Association (APMA), headquartered in Bethesda, Maryland, is the leading resource for foot and ankle health information. Currently, the organization represents a vast majority of the estimated 15,000 podiatrists in the country.

APMA.org

About APMA

APMA news

PREPARE FOR YOUR APPOINTMENT

Foot health is critical to overall health. Learn more about how to prepare for your appointment with a podiatrist.

DOWNLOAD PDF

PATIENT BROCHURE

Download the Today's Podiatrist brochure to help explain the importance of foot health and seeing a podiatrist to patients.

Coming soon!

Exhibit

P

BPM's Continuing Competence Statute and Regulation

B&P Code §2496 enacted by SB 1981 of 1998

2496. In order to ensure the continuing competence of persons licensed to practice podiatric medicine, the board shall adopt and administer regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) requiring continuing education of those licensees. The board shall require those licensees to demonstrate satisfaction of the continuing education requirements and one of the following requirements at each license renewal:

(a) Passage of an examination administered by the board within the past 10 years.
(b) Passage of an examination administered by an approved specialty certifying board within the past 10 years.
(c) Current diplomate, board-eligible, or board-qualified status granted by an approved specialty certifying board within the past 10 years.
(d) Recertification of current status by an approved specialty certifying board within the past 10 years.
(e) Successful completion of an approved residency or fellowship program within the past 10 years.
(f) Granting or renewal of current staff privileges within the past five years by a health care facility that is licensed, certified, accredited, conducted, maintained, operated, or otherwise approved by an agency of the federal or state government or an organization approved by the Medical Board of California.
(g) Successful completion within the past five years of an extended course of study approved by the board.
(h) Passage within the past 10 years of Part III of the examination administered by the National Board of Podiatric Medical Examiners.

Regulation §1399.675

(a) Extended courses of study approved by the board pursuant to Section 2496(g) of the code shall be in addition and supplementary to those taken to meet the continuing education requirement.

(b) Such courses shall provide didactic and clinical training that refreshes and updates knowledge and skills in common podiatric medical and surgical procedures.

(c) Such courses shall examine and test each candidate prior to graduation and certify graduation directly to the board.

(d) The application fee for board approval of each course shall be that specified in Section 2499.5(m) of the Business and Professions Code.

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Procedures for establishing defensible programmes for assessing practice performance

Stephen R Lew,[1] Gordon G Page,[2] Lambert W T Schuwirth,[3] Margarita Baron-Maldonado,[4] Joelle M J Lescop,[5] Neil S Paget,[6] Lesley J Southgate[7] & Winifred B Wade[8]

Summary The assessment of the performance of doctors in practice is becoming more widely accepted. While there are many potential purposes for such assessments, sometimes the consequences of the assessments will be 'high stakes'. In these circumstances, any of the many elements of the assessment programme may potentially be challenged. These assessment programmes therefore need to be robust, fair and defensible, taken from the perspectives of consumer, assessee and assessor. In order to inform the design of defensible programmes for assessing practice performance, a group of education researchers at the 10th Cambridge Conference adopted a project management approach to designing practice performance assessment programmes. This paper describes issues to consider in the articulation of the purposes and outcomes of the assessment, planning the programme, the administrative processes involved, including communication and preparation of assessees.

Examples of key questions to be answered are provided, but further work is needed to test validity.

Keywords clinical competence/*standards; physician, family/*standards; education, medical/*standards; quality of health care/standards.

Medical Education 2002;36:936–941

Introduction

Assessment of the performance of doctors in practice, or practice performance assessment, while conducted informally for many years, is now being formalised. The assessment of performance can involve a constellation of activities, ranging from informal physician self-assessment, to more formally structured external practice assessment processes imposed by licensing, registration, certification or re-certification bodies. For most doctors, these activities provide reinforcement of effective practice and identify educational needs. For a small percentage of doctors, however, these activities identify serious deficiencies in practice performance and provide a basis for formal action related to prescribed remedial education, restricted licensure, or even removal of licensure.

In high stakes performance assessments, it is especially important that the outcomes of the assessment provide a comprehensive and accurate portrayal of the doctor's practice performance. Such assessments must be fair to the doctor being reviewed, and fair to the public and other stakeholder groups whose interests are being served by the assessment.

Practice performance assessment can be viewed as a process of:

- gathering information that describes what doctors do in their care of patients, that is, their practice performance, and
- comparing that information with defined standards of practice performance, to arrive at decisions or judgements about the quality of that performance.

For such assessments to be defensible, both the data gathering process and the judgement process must be defensible. In high stakes situations where a doctor's privilege to practise medicine is in question, experience has shown that it is most often the data gathering phase of this process that is challenged.[1]

[1]Royal Australian College of General Practitioners, Melbourne, Australia, [2]Division of Educational Support and Development, University of British Columbia, Vancouver, Canada, [3]Department of Educational Development, Maastricht University, The Netherlands, [4]Department of Physiology, University of Alcalá, Madrid, Spain, [5]Medical School of Quebec, Montreal, Canada, [6]Royal Australasian College of Physicians, Sydney, Australia, [7]Centre for Health Informatics and Multiprofessional Education, University College London, UK, [8]Royal College of Physicians, London, UK

Correspondence: Dr Stephen R Lew, Royal Australian College of General Practitioners, 1 Palmerston Crescent, South Melbourne, Victoria, Australia. Tel.: 00 61 3 9214 1409; Fax: 00 61 3 9214 1583; E-mail: stephen.lew@racgp.org.au

Jim Rathlesberger

From: Bazzo, David [dbazzo@mail.ucsd.edu]
Sent: Tuesday, September 28, 2010 8:16 PM
To: Jim Rathlesberger; Bethany DeAngelis
Subject: FW: Meeting today
Attachments: Procedures for developing defensible passing scores.pdf; Procedures for esta defensible assess Med Educ.pdf

Dear Jim and Bethany,
FYI, here is an email I sent regarding our meeting this morning.
Thanks and I'll keep you updated,
David

From: Bazzo, David
Sent: Tuesday, September 28, 2010 8:09 PM
To: 'rchristman@westernu.edu'; Lawrence B. Harkless, DPM; 'ksatterfield@westernu.edu'
Subject: Meeting today

Dear Drs. Harkless, Satterfield and Christman,
Thank you for a wonderful meeting this morning. I'm delighted that you are interested in pursuing the development of a program to help to meet the licensure requirement of our state. As I stated, the Podiatric Board of California is a leader in the maintenance of licensure movement and you are to be commended for participating in creating an assessment program to validate competency.
As I stated, I'm happy to be part of the process as much or as little as you like and make myself available to suit your needs. Please let me know at your earliest convenience the potential available dates for our next meeting here in San Diego.
Attached you will find an article regarding standard setting and I've included a second article that describes some of the criteria for establishing a defensible assessment. I've also sent an email to my colleagues at the NBME to have them give additional information regarding the process and supporting literature.
Thanks and I look forward to our next meeting,
Warm regards,
David

David E.J. Bazzo, M.D., FAAFP
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University of California, San Diego, School of Medicine
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Associate Director, UCSD PACE Program
Co-Director, Primary Care Core Clerkship
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San Diego, CA 92110
619-543-6770
f: 619-543-2353
Clinical Office:
9909 Mira Mesa Blvd., Suite 200
San Diego, CA 92131
858-657-7750
f: 858-566-2431

Procedures for Establishing Defensible Absolute Passing Scores on Performance Examinations in Health Professions Education

Steven M. Downing
Ara Tekian
Rachel Yudkowsky
Department of Medical Education
University of Illinois at Chicago
Chicago, Illinois, USA

Background: *Establishing credible, defensible, and acceptable passing scores for performance-type examinations in real-world settings is a challenge for health professions educators. Our purpose in this article is to provide step-by-step instructions with worked examples for 5 absolute standard-setting methods that can be used to establish acceptable passing scores for performance examinations such as Objective Structured Clinical Examinations or standardized patient encounters.*
Summary: *All standards reflect the subjective opinions of experts. In this "how-to" article, we demonstrate procedures for systematically capturing these expert opinions using 5 research-based methods (Angoff, Ebel, Hofstee, Borderline Group, and Contrasting Groups). We discuss issues relating to selection of judges, use of performance data, and decision-making processes.*
Conclusions: *Different standard-setting methods produce different passing scores; there is no "gold standard." The key to defensible standards lies in the choice of credible judges and in the use of a systematic approach to collecting their judgments. Ultimately, all standards are policy decisions.*

Teaching and Learning in Medicine, *18*(1), 50–57

Establishing credible, defensible, and acceptable passing or cutoff scores for performance-type examinations in health professions education can be challenging.[1–3] There is a large literature of standard setting, much of which has been devoted to empirical passing score studies and comparisons of various standard-setting methods that are appropriate for selected-response tests or performance tests used in kindergarten through Grade 12 educational settings.[4–7] Standards can be categorized as either relative (norm based) or absolute (criterion based). Relative standards identify a group of passing and failing examinees relative to the performance of some well-defined group; the passing score or standard will depend on the performance of the specific group tested—for example, the bottom 5% of the class or those who score more than 1 *SD* below the mean. Absolute standards are based on a predetermined level of competency that does not depend on the performance of the group—for example, a score of 70%. Our purpose in this article is to describe specific procedures to carry out five different absolute standard-setting methods, each of which can be used to establish acceptable passing scores for performance examinations, such as Objective Structured Clinical Examinations (OSCEs) or standardized patient examinations, in health professions settings. This is a "how to" article, with the major emphasis on step-by-step instructions and worked examples of each of the five methods: Angoff,[8] Ebel,[9] Hofstee,[10,11] Borderline Group,[7] and Contrasting Groups.[7,12,13] Although each of the standard-setting methods exemplified here is research based, our primary objective in this article is to demonstrate how to apply the methods in

Correspondence may be sent to: Steven M. Downing, Associate Professor of Medical Education, University of Illinois at Chicago, College of Medicine, Department of Medical Education (MC 591), 808 South Wood Street, Chicago, IL 60612–7309, USA. E-mail: sdowning@uic.edu

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CONTINUING COMPETENCE--*CONTINUING DEBATE*

"Currently no state medical board requires physicians to demonstrate their continuing competence to practice, and efforts to strengthen the requirements for relicensing physicians have been successfully opposed by professional organizations. As a result, many physicians continue for decades to practice medicine with little change from what they learned in medical school and hospital residency. States are stricter in testing the skills of motor vehicle drivers."

--Thomas H. Meikle Jr., MD, President, Josiah Macy Jr. Foundation, "States Must Act to Reform Medical Education," *The Journal of American Health Policy*, March/April 1992, Vol. 2, No. 2

"The issue of continuing competency assessment is gaining political force. . . . Boards, as the bodies responsible for licensing physicians, are increasingly going to have to respond to this concern. Or others will!"

--Mark R. Yessian, PhD, "How Can State Medical Boards Compete in the Quality Assurance Marketplace?," *Federation Bulletin*, Federation of State Medical Boards, Vol. 81, No. 2, 1994

"States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals. . . . The evidence that continuing education cannot guarantee continuing competence is sobering."

--*Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*, December 1995, Pew Health Professions Commission

"What is the role of boards in ensuring continuing professional competence? Should boards regulate continuing education providers, or should this be the function of educational organizations and oversight bodies?"

--Kathleen Hamilton, Director, California Department of Consumer Affairs, speaking at Citizen Advocacy Center annual meeting, San Francisco, November 13, 2002 [*News & Views*, Citizen Advocacy Center, Fourth Quarter, 2002. Vol. 14, No. 4]

"It was more than 30 years ago, in the pages of the *Federation Bulletin*, that Robert C. Derbyshire, MD, wrote ' . . . whenever the subject of recertification or re-examination was brought up in almost any medical gathering it was greeted by an uncomfortable silence or open hostility.' I regret to say that during the past three decades the prevailing attitude in the profession toward a physician having to prove his continuing competency has changed little."

--Ronald C. Agresta, MD, FSMB President, "Maintenance of Competency: An Old Emerging Issue," *Journal of Medical Licensure and Discipline*, Federation of State Medical Boards, Vol. 89, No.1, 2003

"It's hard to say when the board will feel that they have gathered enough information and are ready to move ahead. . . . There always is something new that we need to learn about and consider before making a proposal."

--Neal Kohatsu, MD, Medical Director, Medical Board of California, "Maintenance of Competence: The Debate Heats Up," *Journal of Medical Licensure and Discipline*, Federation of State Medical Boards, Vol. 89, No. 1, 2003

"I have given a *lot* of thought to this and brought my staff, faculty (including the former CEO of the American Board of Medical Specialties), our faculty in podiatric medicine, and our colleagues at the National Board of Medical Examiners into the discussion. . . .

"First, you will never know how much we respect the California Board of Podiatric Medicine for being the first Board of any discipline, to our knowledge, to have made a true Maintenance of Competence requirement a legal requirement of licensure. The medical profession is many years away from attaining this enlightenment, if it ever happens at all. We are not aware of any State or country, anywhere in the world, where this is the law. Your Board has done the right thing, and we congratulate you. Your Board will be recounted as heroes in the history books, and I mean this honestly and literally."

--William A. Norcross, M.D., Clinical Professor of Family Medicine, and Director of the Physician Assessment and Clinical Education (PACE) Program, University of California at San Diego, April 2, 2010

Exhibit

Q

New Study Proves Care by Podiatrists Dramatically Decreases Lower Limb Amputation

Research Results Presented at APMA's 98th Annual Scientific Meeting

Bethesda, MD – Essential foot care by a podiatrist has now been statistically proven to reduce hospitalization and amputation in adults with diabetes, according to a first of its kind study conducted by Thomson Reuters. The study was presented by Vickie R. Driver, MS, DPM, during the American Podiatric Medical Association's (APMA) 98th Annual Scientific Meeting in Seattle, July 15-18, 2010. The presentation highlighted the dramatic impact that even a single visit to a podiatrist can have on patients with diabetes.

The study, which was sponsored by APMA, examined records for more than 32,000 patients with diabetes, ages 18-64, and compared health and risk factors for those who had podiatry visits to those who did not. Researchers found that care by a podiatric physician (defined as at least one preventative, pre-ulcer visit) was associated with a nearly 29 percent lower risk of amputation and 24 percent lower risk of hospitalization. Diabetic foot complications are the leading cause of non-traumatic lower limb amputation in the U.S.

"The results of this study undeniably support visits to a podiatrist being critical to a diabetes patient's health and well being," said APMA member Dr. Driver. "No longer can care by a podiatrist be considered optional for those with diabetes, and the earlier a podiatrist is included in the diabetes management team, the better quality of life for the patient and greater health-care cost savings for all involved. This study clearly allows us to understand both the clinical and economic value of a podiatrist, in the team approach to saving diabetic patients' feet."

The study was conducted using Thomson Reuters' MarketScan Research Databases, which house fully integrated, de-identified health-care claims data extensively used by researchers to understand health economics and outcomes. Studies based on MarketScan data have been published in more than 130 peer-reviewed articles in the past five years.

Lead researcher Teresa Gibson, PhD, director of health outcomes research at Thomson Reuters said, "Using the MarketScan Databases, we statistically matched patients with diabetes and foot ulcers who had visited a podiatrist with like patients who had not. The analysis of the data indicates that patients who had seen a podiatrist in the year prior to the onset of a foot ulcer had significantly lower rates of any amputation and hospitalization than those who had not."

For additional information on the study, visit **www.apma.org/diabetesstudy**.

THOMSON REUTERS

HEALTHCARE

PODIATRIST CARE AND OUTCOMES FOR PATIENTS WITH DIABETES AND FOOT ULCER

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APMA

ABSTRACT

The purpose of this study was to examine whether outcomes of care (amputation and hospitalization) differ between patients with diabetes who received care from podiatrists and those who did not.

Adult patients with diabetes (ICD-9-CM: 250.xx) and a diagnosis of foot ulcer (ICD-9-CM: 707.03, 707.06, 707.07, 707.09, 707.10, 707.12, 707.13, 707.14, 707.15) were found in the *Thomson Reuters MarketScan® Research Databases*, 2005–2008. The date of the first claim with evidence of foot ulcer was assigned as the index date. Patients with previous evidence of foot ulcer or amputation were excluded. Propensity score matching (PSM) was used to create a matched sample of patients with diabetes and podiatry visits and patients with diabetes and no podiatrist visits, based on sociodemographic variables, plan type, general health status, adherence to diabetes medications, and risk factors for amputation (patient-level and foot-level). The sample comprised 20,330 patients aged 65+ (Medicare eligible patients with employer-sponsored supplemental insurance) and 11,766 patients aged <65 (non-Medicare-eligible commercially insured patients). Patient experience was available for up to 60 months. Cox proportional hazard models estimated the hazard of inpatient hospitalization, lower extremity amputation, and major amputation (i.e., below the knee or higher), controlling for the covariates in the PSM.

Care by podiatrists, defined as at least 1 pre-ulcer podiatry visit, was associated with lower hazards of hospitalization, amputation, and major amputation in the Medicare population. Results were similar in the non-Medicare population, where the difference in major amputation was not statistically significant ($P > 0.1$). Hazard ratios (HR) and 95% confidence intervals (CI) are presented in the table below. Results were consistent when care by podiatrists was defined as at least 3 pre-ulcer podiatry visits.

	HR	95% CI
Hospitalization		
Medicare	0.910	0.873–0.949
Non-Medicare	0.825	0.777–0.876
Amputation		
Medicare	0.820	0.707–0.952
Non-Medicare	0.852	0.725–1.002
Major Amputation		
Medicare	0.766	0.585–1.002
Non-Medicare	0.771	0.547–1.086

In a population of adults with diabetes and foot ulcer, care by podiatrists appears to prevent or delay lower extremity amputation and hospitalization.

OBJECTIVE

- To examine whether outcomes of care (amputation and hospitalization) differ between patients with diabetes and foot ulcer who received care from podiatrists prior to foot ulcer and those who did not receive care from podiatrists prior to foot ulcer.

METHODS

Data Source

- *Thomson Reuters MarketScan® Research Databases*, 2005–2008
  - Fully adjudicated health insurance claims (inpatient medical, outpatient medical, and outpatient pharmacy) linked to enrollment and demographic data
  - *Commercial Database*
    - Enrollees with employer-sponsored insurance from large and medium-sized firms
  - *Medicare Supplemental Database*
    - Medicare beneficiaries (65+) with employer-sponsored supplemental insurance

Patient Selection

- Inclusion Criteria
  - Patients had to have a diagnosis of diabetes on a medical claim
    - Diagnosis of 250.xx must have occurred on at least one inpatient or two outpatient claims separated by 30+ days
    - Claims for diagnostic procedures (e.g., laboratory tests) were excluded
  - Patients had to have a diagnosis code or procedure code indicating foot ulcer on a medical claim
    - At least one claim with a diagnosis or procedure code indicating foot ulcer
    - The date of the first claim with evidence of foot ulcer was the index date for each patient
  - Patients had to be age 18 or older on the index date
  - Provider specialty coding (i.e., podiatrist care or other provider type) must have been available on the claims
  - Patients must have been continuously enrolled with medical and outpatient prescription drug coverage in the 12 months before the index date
- Exclusion Criteria
  - Evidence of foot ulcer during the 12-month pre-index period
  - Evidence of amputation during the 12-month pre-index period
  - ICD-9-CM and CPT codes available from authors

Variables

- Outcome Variables
  - Time from date of first evidence of foot ulcer until each event was measured in days for three outcomes
    - Lower extremity amputation (major and/or minor)
    - Major amputation (below the knee or higher)
    - Hospitalization
- Key Explanatory Variable
  - Patients were classified as having at least one podiatrist visit (case) or not (comparison) during the 12 months prior to the date of the first evidence of foot ulcer
- Control Variables
  - Control variables were measured on the index date or in the year prior to the index date (comorbidities, patient-level risk factors, foot-level risk factors, health behavior)
  - Demographic characteristics: age group and gender
  - Geography: urban residence and US Census region
  - Employment status: employee/spouse/dependent and salaried (versus hourly wage)
  - Socioeconomic status (from 2000 US Census): median household income and percentage of population aged 24+ with college degree in the patient's ZIP code of residence
  - Comorbidity: Charlson Comorbidity Index and number of psychiatric diagnosis groups
  - Patient-level risk factors: cardiovascular, nephropathy, and eye disease
  - Foot-level risk factors: peripheral arterial disease, neuropathy, foot deformity, callus, other (including cellulitis, abscess, boil, etc.)
  - Health behavior: adherence to diabetes prescriptions (i.e., medication possession ratio)
  - Plan characteristics: plan type (e.g., HMO) and firm-level proportion of patients with podiatrist visits (as a measure of generosity toward podiatric care)
  - Time: index year and months of follow-up data available

Analytic Approach

- Propensity Score Matching
  - Patients receiving care from podiatrists were matched one-to-one with patients not receiving care from podiatrists using propensity score methods.
  - Logistic regression models of the probability of receipt of podiatrist care as a function of the control variables were estimated (propensity score). Patients receiving podiatrist care were matched to those who had not based on the value of the propensity score
  - Propensity score matching was performed separately for commercially insured enrollees and Medicare eligible enrollees
- Statistical Models
  - Cox proportional hazard models estimated the hazard of each outcome as a function of receipt of podiatry care and the control variables

RESULTS

Sample Size

- After all inclusion and exclusion criteria were applied, the non-Medicare sample comprised 28,796 patients, the Medicare sample comprised 35,721 patients.

Differences in Baseline Characteristics

- Prior to matching, patients with podiatrist visits were significantly older and had significantly more comorbidities than patients without podiatrist visits (not shown)
- After matching, few significant differences in patient characteristics remained. Select demographic and clinical characteristics of the matched groups are shown in Table 1.

Table 1. Sample Characteristics after Matching for Patients with Diabetes and Foot Ulcer

Characteristic	Non-Medicare: Podiatrist Visit (Case) n = [illegible]	Non-Medicare: No Podiatrist Visit (Comparison) n = [illegible]	p-Value	Medicare: Podiatrist Visit (Case) n = [illegible]	Medicare: No Podiatrist Visit (Comparison) n = [illegible]	p-Value
Age Group						
18–34	[illegible]	1.0%	[illegible]	0.0%	0.0%	[illegible]
35–44	4.5%	[illegible]	[illegible]	0.0%	0.0%	[illegible]
45–54	[illegible]	[illegible]	[illegible]	[illegible]	0.3%	[illegible]
55–64	[illegible]	[illegible]	0.001	[illegible]	[illegible]	[illegible]
65–74	[illegible]	0.0%	[illegible]	[illegible]	[illegible]	[illegible]
75–84	[illegible]	0.0%	[illegible]	[illegible]	[illegible]	[illegible]
85 and older	[illegible]	0.0%	[illegible]	[illegible]	[illegible]	[illegible]
Female	47.2%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Insurance Plan Type						
Comprehensive	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
HMO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
POS / EPO	[illegible]	[illegible]	[illegible]	1.7%	[illegible]	[illegible]
PPO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
POS with capitation	[illegible]	[illegible]	[illegible]	0.0%	[illegible]	[illegible]
CDHP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Missing	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Urban Residence	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Geographic Region						
Northeast	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
North Central	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
South	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
West	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Unknown	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Median Household Income in ZIP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Percent College Graduates in ZIP	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Charlson Comorbidity Index	[illegible]	2.51	[illegible]	[illegible]	[illegible]	[illegible]
Psychiatric Diagnosis Groups	[illegible]	0.21	[illegible]	[illegible]	[illegible]	[illegible]
Medication Possession Ratio	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Patient-Level Risk Factors						
Cardiovascular	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Nephropathy	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Eye	[illegible]	14.5%	[illegible]	[illegible]	[illegible]	[illegible]
Foot-Level Risk Factors						
Neuropathy	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Peripheral arterial disease	14.2%	14.0%	[illegible]	[illegible]	[illegible]	[illegible]
Foot deformity	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Callus	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Other (e.g., cellulitis, abscess, boil)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Results of Cox Proportional Hazard Models

- Among non-Medicare patients with foot ulcer, those seen previously by a podiatrist had a 15% lower risk of amputation and a 17% lower risk of hospitalization compared with patients not seen previously by a podiatrist ($P < 0.05$). The difference in risk of major amputation was not statistically significant between patients receiving care from podiatrists and those who did not ($P > 0.05$) (Table 2).
- Among Medicare-eligible patients with foot ulcer, those seen previously by a podiatrist had an 18% lower risk of amputation, a 23% lower risk of major amputation, and a 9% lower risk of hospitalization compared with patients not seen previously by a podiatrist (all $P < 0.05$) (Table 2).
- Kaplan-Meier curves illustrate the unadjusted amount of time to amputation; patients seen previously by a podiatrist have a longer amputation-free survival time compared with patients not seen previously by a podiatrist (Figures 1a and 1b).

Figure 1a. Kaplan-Meier Curves: Unadjusted Time to Lower Extremity Amputation (Non-Medicare)

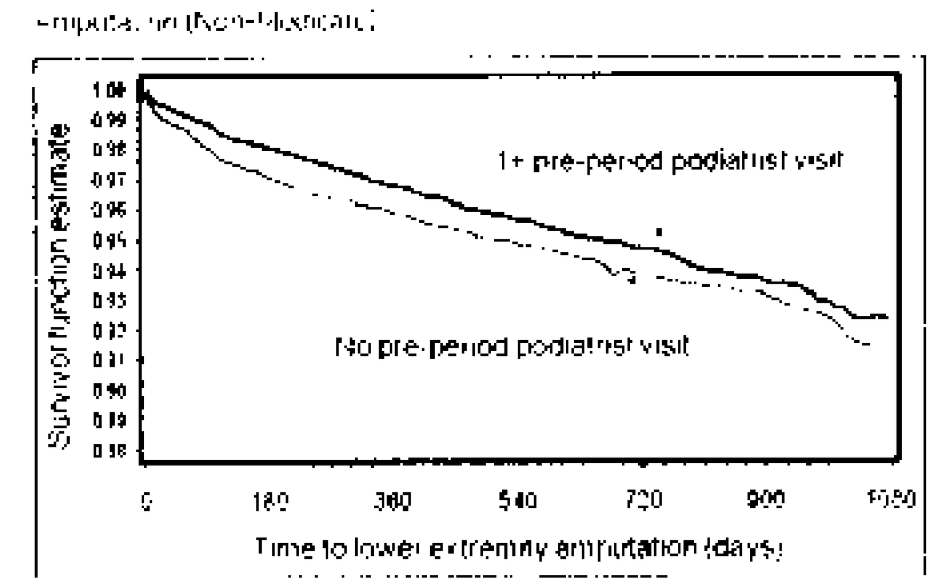

Figure 1b. Kaplan-Meier Curves: Unadjusted Time to Lower Extremity Amputation (Medicare)

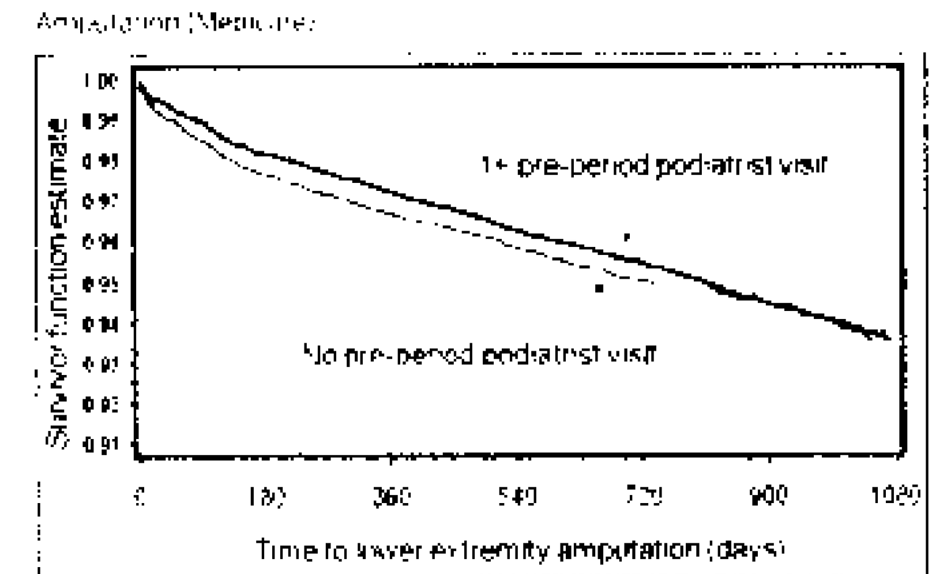

Table 2. Adjusted Hazard Ratios (HR) Associated with Pre-Period Podiatric Medical Care for Patients with Diabetes and Foot Ulcer

Event	Non-Medicare Patients N = 11,766: Adj. HR	95% CI	Medicare-Eligible Patients N = 20,330: Adj. HR	95% CI
Amputation	0.852	0.725–1.002	0.820	0.707–0.952
Major Amputation	0.771	0.547–1.086	0.766	0.585–1.002
Hospitalization	0.825	0.777–0.876	0.910	0.873–0.949

Control variables included sociodemographic characteristics, comorbidity, patient-level risk factors, foot-level risk factors, health behavior, plan type, and firm.

Sensitivity Analysis

- Analyses were replicated using the unmatched samples and the results were consistent.
- Because a larger number of podiatrist visits may have a greater clinical effect, the analyses were replicated with [illegible] and the results were consistent.

LIMITATIONS

- This retrospective, observational study was based on codes of diagnoses, procedures, and provider type from healthcare administrative claims.
- The sample comprised patients with employer-sponsored health insurance (alone or supplemental to Medicare); the results may not generalize to other populations.

CONCLUSIONS

- In a sample of commercially insured patients with diabetes and foot ulcers (non-Medicare and Medicare-eligible with employer-sponsored supplemental insurance), care by podiatrists prior to the first evidence of foot ulcer appears to prevent or delay hospitalization and amputation.

CONTACT

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American Podiatric Medical Association
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[illegible]

Exhibit

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SELECTION OF MEETING DATES

- 2011 -

Initial Staff Suggestions

February 11 -- Bay Area

June 17 -- Sacramento

September 23 -- Southern California

Calendar for year 2011 (United States)

January

Su	Mo	Tu	We	Th	Fr	Sa
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2	3	4	5	6	7	8
9	10	11	12	13	14	15
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February

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June

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September

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November

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December

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Holidays and Observances:

Jan 1	New Year's Day	May 30	Memorial Day	Oct 31	Halloween
Jan 17	Martin Luther King Day	Jun 19	Father's Day	Nov 11	Veterans Day
Feb 14	Valentine's Day	Jul 4	Independence Day	Nov 24	Thanksgiving Day
Feb 21	Presidents' Day	Sep 5	Labor Day	Dec 21	First Day of Chanukah
Apr 19	First day of Passover	Sep 29	Rosh Hashana	Dec 24	Christmas Eve
Apr 24	Easter Sunday	Oct 8	Yom Kippur	Dec 25	Christmas Day
Apr 26	Last day of Passover	Oct 10	Columbus Day (Most regions)	Dec 26	'Christmas Day' observed
May 8	Mother's Day	Oct 19	Last day of Sukkot	Dec 28	Last day of Chanukah

Calendar generated on www.timeanddate.com/calendar